§ 434.34 Quality assurance system.

The contract must provide for an internal quality assurance system that:

(a) Is consistent with the utilization control requirement of part 456 of this chapter;

(b) Provides for review by appropriate health professionals of the process followed in providing health services;

(c) Provides for systematic data collection of performance and patient results;

(d) Provides for interpretation of this data to the practioners; and

(e) Provides for making needed changes.

[48 FR 54013, Nov. 30, 1983; 49 FR 9173, Mar. 12, 1984]

§ 434.36 Marketing.

The contract must specify the methods by which the HMO or PHP will assure the agency that marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the agency.

[53 FR 12016, Apr. 12, 1988]

§ 434.38 Inspection and audit of HMO's financial records.

A risk comprehensive contract with an HMO must provide that the agency and the Department may inspect and audit any financial records of the HMO or its subcontractors relating to the HMO's capacity to bear the risk of potential financial losses.

Subpart D—Contracts With Health Insuring Organizations

SOURCE: 55 FR 51295, Dec. 13, 1990, unless otherwise noted.

§ 434.40 Contract requirements.

(a) Contracts with health insuring organizations that are not subject to the requirements in section 1903(m)(2)(A) must:

(1) Meet the general requirements for all contracts and subcontracts specified in § 434.6;

(2) Specify that the contractor assumes at least part of the underwriting risk and;

(i) If the contractor assumes the full underwriting risk, specify that payment of the capitation fees to the contractor during the contract period constitutes full payment by the agency for the cost of medical services provided under the contract;

(ii) If the contractor assumes less than the full underwriting risk, specify how the risk is apportioned between the agency and the contractor;

(3) Specify whether the contractor returns to the agency part of any savings remaining after the allowable costs are deducted from the capitations fees, and if savings are returned, the apportionment between agency and the contractor; and

(4) Specify the extent, if any, to which the contractor may obtain reinsurance of a portion of the underwriting risk.

(b) The contract must—

(1) Specify that the capitation fee will not exceed the limits set forth under part 447 of this chapter.

(2) Specify that, except as permitted under paragraph (b) of this section, the capitation fee paid on behalf of each recipient may not be renegotiated—

(i) During the contract period if the contract period is 1 year or less; or

(ii) More often than annually if the contract period is for more than 1 year.

(3) Specify that the capitation fee will not include any amount for recoupment of any specific losses suffered by the contractor for risks assumed under the same contract or a prior contract with the agency; and

(4) Specify the actuarial basis for computation of the capitation fee.

(c) The capitation fee may be renegotiated more frequently than annually for recipients who are not enrolled at the time of renegotiation or if the renegotiation is required by changes in Federal or State law.

§ 434.42 Application of sanctions to risk comprehensive contracts.

A risk comprehensive contract must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by HCFA under § 434.67(e).

[59 FR 36084, July 15, 1994]

§ 434.44 Special rules for certain health insuring organizations.

(a) A health insuring organization that first enrolls patients on or after January 1, 1986, and arranges with other providers (through subcontract, or through other arrangements) for the delivery of services (as described in § 434.21(b)) to Medicaid enrollees on a prepaid capitation risk basis is—

(1) Subject to the general requirements set forth in § 434.20(d) concerning services that may be covered and § 434.20(e) which sets forth the requirements for all contracts, the additional requirements set forth in §§ 434.21 through 434.38 and the Medicaid agency responsibilities specified in subpart E of this part; and

(2) To be organized under the appropriate laws, including corporation laws, of the State in which it operates. There is no Federal requirement that an HIO be organized under a State'a HMO law, if it has one. However, the health insuring organization must meet the State plan definition requirements in § 434.20(c) (1), (2) and (3) of this chapter.

(b) *Special exemption.* Any health insuring organization subject to the requirements in paragraph (a) of this section, that is operating under the authority of a waiver granted to a State under section 1915(b) of the Act prior to January 1, 1986, is exempt from those requirements relating to composition of enrollment and disenrollment without cause in §§ 434.26 and 434.27(b), during the effective period of the waiver, including extensions and renewals.

[55 FR 51295, Dec. 13, 1990, as amended at 61 FR 13449, Mar. 27, 1996]

Subpart E—Contracts with HMOs and PHPs: Medicaid Agency Responsibilities

SOURCE: 48 FR 54020, Nov. 20, 1983, unless otherwise noted. Redesignated at 55 FR 51295, Dec. 13, 1990.

§ 434.50 Proof of HMO or PHP capability.

The agency must obtain from each contractor proof of—

(a) Financial responsibility, including proof of adequate protection against insolvency; and

(b) The contractor's ability to provide the services under the contract efficiently, effectively, and economically.

[48 FR 54020, Nov. 30, 1983; 48 FR 55128, Dec. 9, 1983]

§ 434.52 Furnishing of required services.

The agency must obtain assurances from each contractor that—

(a) It furnishes the health services required by enrolled recipients as promptly as is appropriate; and

(b) The services meet the agency's quality standards.

§ 434.53 Periodic medical audits.

(a) The agency must establish a system of periodic medical audits to insure that each contractor furnishes quality and accessible health care to enrolled recipients.

(b) The system of periodic medical audits must—

(1) Provide for audits conducted at least once a year for each contractor;

(2) Identify and collect management data for use by medical audit personnel; and

(3) Provide that the data includes—

(i) Reasons for enrollment and termination; and

(ii) Use of services.

§ 434.57 Limit on payment to other providers.

The agency must ensure that, except as specified in § 434.30(b) for emergency services, no payment is made for services furnished by a provider other than the contractor, if the services were available under the contract.

§ 434.59 Continued service to recipients whose enrollment is terminated.

The agency must arrange for Medicaid services without delay for any recipient whose enrollment is terminated, unless it is terminated because of ineligibility for Medicaid.

§ 434.61 Computation of capitation fees.

The agency must determine that the capitation fees and any other payments provided for in the contract are computed on an actuarially sound basis.